

Exhibit A

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: **California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.**

Name: <u>JANE PATRICIA BARNES</u>	Social Security No.: <u>[REDACTED]</u>
Address: <u>3481 Euclid AVE Concord, CA 94519</u>	Telephone No.: <u>925-671-9197</u>

1. In your own words, tell us why you cannot work in your own or in any occupation.
my low back and tailbone cause me so much pain that it interferes with my ability to sit, concentrate, focus, or follow through on a daily basis. I suffer from regular headaches, leg pain, butt pain & an irritated bowel which make it difficult to attend to any regular employment.
2. What is primary physical and/or mental condition preventing you from working now?
chronic pain syndrome; sciatica; degenerative lumbar/cervical disc disease; neuropathic pain; post L5/S1 microdissection and post anterior L5/S1 fusion; post five-level IDET; irritable bowel syndrome; dislocated tailbone; dislocated knee cap(s).
3. Can you drive? ☒ Yes ☐ No How far? as needed; to doctors - with increased pain
usually only errands close by.
4. What time do you get up in the morning? 9-10 am What time do you go to bed? 10-11 pm

5. Where do you live? ☐ Apartment ☒ House
 How many floors in the apartment/house? 1 Does it have an elevator? ☐ Yes ☒ No
 Do you use any special equipment - ramps, handrails, wheelchair? ☐ Yes ☒ No
 If yes, describe _____
6. How often do you use the computer? as needed for personal banking, daily or almost daily
 What computer programs or software can you use? Microsoft Office, Word, Excel, a wide range

7. Check the things you do regularly:

Activity	Hours per day?	Days per week?
<input checked="" type="checkbox"/> Cook	<u>1 hr</u>	<u>4 to 5</u>
<input checked="" type="checkbox"/> Clean	<u>0-15 min</u>	<u>2 to 3</u>
<input checked="" type="checkbox"/> Shop	<u>0-30 min</u>	<u>1 to 2</u>
<input checked="" type="checkbox"/> Laundry	<u>0-30 min</u>	<u>1</u>
<input checked="" type="checkbox"/> Yardwork	<u>15-30 min</u>	<u>3 to 4 - light only</u>
<input checked="" type="checkbox"/> Gardening	<u>15-30 min</u>	<u>4 to 5 - light only</u>
<input type="checkbox"/> Read	<u>1 hr</u>	<u>daily</u>
<input type="checkbox"/> Watch TV	<u>2 hr</u>	<u>4 to 5</u>
<input type="checkbox"/> Other (school, attend religious services, volunteer work, etc.) <u>list work off time</u>	<u>1 to 2 hr</u>	<u>daily</u>

What do you do for recreation? play with 2 children, walk with friends, gardening, go for drives with friends

8. Are there things you attend to with regard to your personal needs (grooming, dressing, etc.)?
I shower as needed; I get dressed daily; I take my medicines as needed; I frequently use make-up; I get my hair cut weekly.
9. Do you go for walks? ☒ Yes ☐ No How often? almost daily with occasional missed days
 How far do you walk? about 20-40 min For how long? about 20-40 min
about 20-40 min to park about 20-40 min to park about 20-40 min to park

10. Do you engage in a regular exercise program? ☒ Yes ☐ No I TRY TO
 Where (home, gym, etc.) local dog park for walk; community pool for swimming
 How often? walk daily usually; I swim two times per week when possible
 Describe your exercise program walk daily with some swimming, weekly
I also have therapeutic bodywork about once per week
11. Please circle the highest grade you completed in school: 15.1
 1 2 3 4 5 6 7 8 9 10 11 12 GED High School Diploma
 College? 1 yr. 2 yrs. 3 yrs. 4 yrs. BA/BS Degree Masters Degree Other 15.1
 Type of degree? (Business, History, Social Sciences, etc.) BS, MS, PhD
 Date Received '79, '81, '85 → BS-Agriculture, Horticulture MS & PhD
 List any professional/educational certificates, licenses, etc. awarded _____
 List any vocational programs you have attended/completed _____
 In the last 3 years, what type of certificates or licenses have you received? _____
12. Are you taking any professional/educational/vocational classes now? ☐ Yes ☒ No
 Please list them _____
13. Are you working? ☐ Yes ☒ No
 If so, please list how many hours per day you work, and the name of your employer. _____
14. Have you discussed return to work with your physician? ☐ Yes ☒ No
 What does your physician say about returning to work? we have not discussed in last yrs
15. When do you expect to return to work? unsure if ever will be able
 Will you return to your regular occupation? ☐ Yes ☒ No If no, why not? not available; not able to find job
 Will you return to Modified job? ☐ Yes ☐ No If no, why not? not available; not physically able
16. Do you know of any positions within your company that you would be interested in? ☐ Yes ☒ No
 If yes, what position? company terminated me & eventually closed site
17. If unable to return to regular position, would you be interested in exploring your career options? ☐ Yes ☒ No
I have already explored options with worker compensation.

Employment History

1. Job Title: <u>PRINCIPAL RESEARCH CHEMIST</u>	Employed date: From: <u>94</u> Through: <u>97</u>
Major Duties: <u>Complete research studies for EPA submission</u>	Minor Duties: <u>Quality assurance, training</u>
Tools/Equipment used: <u>computer, HPLC, GC, balance etc</u>	Machinery/Computers used: <u>computer IBM</u>
2. Job Title: <u>Principal Research Biochemist</u>	Employed date: From: <u>92</u> Through: <u>94</u>
Major Duties: <u>Team leader, study director, supervisor</u>	Minor Duties: <u>train</u>
Tools/Equipment used: <u>All chromatography stuff, computer</u>	Machinery/Computers used: <u>IBM computer</u>
3. Job Title: <u>Senior Research Biochemist</u>	Employed date: From: <u>90</u> Through: <u>92</u>
Major Duties: <u>Team leader, study director</u>	Minor Duties: <u>train, teach section</u>
Tools/Equipment used: <u>all lab equipment</u>	Machinery/Computers used: <u>IBM computer</u>

18. Have you ever owned or operated your own business? ☐ Yes ☒ No
 Do you own, operate or have ownership interest in a business now? ☐ Yes ☒ No
 Business Name _____

19. Are you married, or do you have a domestic partner? ☒ Yes ☐ No *married 10/22/04*
 Do you have any children under age 25? ☒ Yes ☐ No *Stepdaughter - 20*
 Do you have any handicapped children (regardless of age)? ☐ Yes ☒ No
 If you answered "Yes" to any of the above questions, please list below.

	NAME	RELATIONSHIP	GENDER (M/F)	DATE OF BIRTH	SOCIAL SECURITY NO.
1.	VICTOR RODRIGUES	husband	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	9/16/1951	
2.	VERONICA RODRIGUES	step-daughter	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	12/27/1984	
3.			<input type="checkbox"/> M <input type="checkbox"/> F		
4.			<input type="checkbox"/> M <input type="checkbox"/> F		
5.			<input type="checkbox"/> M <input type="checkbox"/> F		

20. List any prescription medications you take: Use other side if you need more space. *See extra sheet*

	Medication	Dose	Frequency	Medication	Dose	Frequency
1.	oxycontin	3.40 mg	3 times/day	Ambien	10 mg	nightly
2.	NORCO	10 mg	3-4 per day	Toprol	2	daily
3.	Effexor XR	150 mg	nightly	Provigil	200 mg	daily

21. List any doctor(s) you see regularly. Use the other side if you need more room. *See extra sheet*

Doctor's Name/Specialty: <i>MD, MB, CHB, FRCP C.</i> DR Marnie Joel, Pain Management		Doctor's Name/Specialty: <i>MD, Elizabeth Gurnea</i> DR Fillmore, RN, NP - Gyn	
Address: <i>15035 East 14th Street</i> <i>San Leandro, CA 94578</i>		Address: <i>2299 Bacon St Ste 1</i> <i>Concord CA 94596</i>	
Telephone #: <i>510-734-0226</i> Fax #: <i>unknown</i>	Frequency of visits: <i>quarterly</i> Date of last visit: <i>Sept 2004</i>	Telephone #: <i>925-676 3450</i> Fax #: <i>don't have it</i>	Frequency of visits: <i>once per year</i> Date of last visit: <i>Oct 2005</i>
Doctor's Name/Specialty: <i>DR John Toth, D.O., GP</i> Address: <i>2270 Bacon St</i> <i>Concord CA 94520</i>		Doctor's Name/Specialty: <i>DR Weir - GI</i> Address: <i>He prescribes my GI related meds</i> <i>But I have not seen recently - he had back surgery</i>	
Telephone #: <i>925-687-9447</i> Fax #: <i>925 687 9483</i>	Frequency of visits: <i>when I see him</i> Date of last visit: <i>Oct 2004</i>	Telephone #: <i>510 460-0246</i> Fax #: <i>415 550 1700</i>	Frequency of visits: <i>irregular but</i> Date of last visit: <i>a few years ago</i>

22. Are you right handed or left handed? ☒ Right ☐ Left
 What is your height? *5' 7 inches*
 What is your weight? *215 lbs*
 What is your date of birth? *June 13, 1957*

23. Are you a veteran? ☐ Yes ☒ No
 If yes, have you applied for VA benefits for this disability? ☐ Yes ☒ No
 Please attach a copy of your VA disability award.

24. What other types of income/money/compensation/benefits are you receiving or eligible to receive?

	\$ Amount/Frequency	Date Began	Date Paid Through
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Salary Continuance			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No State Disability Benefits			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Group Disability Benefits			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Workers' Compensation			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pension Benefits			
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Social Security Disability Benefits	<i>NOTE: Social Security rate is different each year; \$1532 only since Jan 05.</i>	<i>12/12/98</i>	<i>10-19-05</i>
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No No-Fault Auto Disability Insurance			
<input type="checkbox"/> Yes <input type="checkbox"/> No Any Other Disability Income			

I certify that the information in this document is true and correct.

Signature

Janet Barnes

Date

Oct 20, 2005

Exhibit B

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: **California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.**

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

The insured is responsible for having this form completed by any/all treating physician(s) without expense to the company. We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED

1. NAME <u>Ane Patricia Barnes</u>		EMPLOYER NAME <u>WAS General Ag Products</u>
ADDRESS <u>3481 Euclid Ave</u>		SOCIAL SECURITY NUMBER <u>[REDACTED]</u>
CITY <u>Concord</u>	STATE <u>CA</u>	ZIP CODE <u>94519</u>
TELEPHONE <u>925 671 9197</u>	OCCUPATION <u>was scientist</u>	DATE OF BIRTH <u>6-13-1957</u>

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1.	DIAGNOSIS (Including any complications) (a) Diagnosis (Include ICD-9 or DSM-IV Code) <u>multilevel lumbar disc disease T22.52</u> <u>cervical disc disease T22.4</u>	
	(b) Subjective symptoms <u>pt can not sit for prolonged periods of time. When the pt tries to do any light work, she feels immediate pain in her back.</u>	
	(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.) <u>Back pain in lumbar, exquisite tenderness over lumbosacral. Pt can not sit, severe numbness, (+) positive sign, severe (+) R side</u>	
	(d) Are symptoms consistent with the clinical findings? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, explain _____	
	(e) Is illness work related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____	
2.	DATES OF TREATMENT • Date patient first visited you for this accident/illness: <u>7 14 1999</u> • Date patient first unable to work due to this accident/illness: <u>pt was permanently disabled</u> • List frequency & date(s) patient was examined for this accident/illness: <u>every 3-15 days</u> • Date of last visit: <u>6 2 05</u> <u>at MD office</u>	
3.	NATURE OF TREATMENT (including Surgery & Medications prescribed, if any) Hospitalization on: _____ Month Day Year THROUGH _____ Month Day Year Surgery on: _____ Month Day Year Type of Surgery: _____ Name and Address of Hospital: _____ Medications-type/dosage: _____ Medications-type/dosage: _____	

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8 hour day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours	Cardiac - If applicable (American Heart Association)
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Class 1 - No Limitation
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Class 2 - Slight Limitation
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Class 3 - Marked Limitation
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Class 4 - Complete Limitation
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull _____

Sedentary = 10 lbs. maximum, walking occasionally. Light = 20 lbs. maximum, 10 lbs. frequently

Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. Heavy = 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

II: _____

III: _____

IV: _____

V: Current GAF: _____ Highest GAF in past year: _____

Additional Comments: _____

6. RETURN TO WORK STATUS

Patient's Regular Occupation

Any Occupation

When was patient able to go to work?

permanently Disabled

Month Day Year

Month Day Year

7. REHABILITATION

(a) Is patient a suitable candidate for further PHYSICAL / PSYCHOLOGICAL rehabilitation services?

☐ Yes☒ No

If no, explain: _____

8. REMARKS

DATE 11-3-05	PRINT NAME (ATTENDING PHYSICIAN) Nannu J. M.D.	SIGNATURE 	DEGREE MD
TELEPHONE NUMBER 510-278-6266		PROVIDER TAX ID NUMBER 640810772	
STREET ADDRESS 15035 E. H+H St.			
CITY OR TOWN San Leandro		STATE (OR, PROVINCE) CA	ZIP CODE 94578